Name of Applicant _____

Address _____

_____

_____

Telephone No. _____

Representing _____

Important Notice: This REQUEST FOR HEARING shall be mailed by certified mail by the requesting party to all parties. A certificate of mailing shall be filed with this request. If an attorney has entered an appearance for a party, mailing to the attorney is mandatory. This request will not be accepted for filing unless it contains all information as required under §12-10-72.1 of the Hawaii Administrative Rules.

STATE OF HAWAII

DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

DISABILITY COMPENSATION DIVISION

_____	)	Case No. _____
_____	)	
_____	)	Date of Injury _____
(Claimant Name and Address)	)	
	)	
Claimant,	)	
	)	
vs.	)	
_____	)	
_____	)	
_____	)	
(Employer/Carrier)	)	
	)	
Emp/Carr	)	
_____	)	

REQUEST FOR HEARING

Comes now, _____ above-named and hereby requests that a hearing be scheduled on this matter on the issue(s) as noted below:

1. SUMMARY

Provide an explanation of issue(s) in dispute: 1) Why you were unable to resolve the dispute, and 2) The remedy or award you are seeking.

_____

_____

_____

_____

2. STATEMENT OF THE ISSUE(S) TO BE DETERMINED AT THE HEARING (Check Applicable Space(s))

___ REVIEW OF EMPLOYER'S DENIAL OF HEALTH CARE. Attach the Treatment Plan. If not available, attach a letter of explanation (Cost Review).

___ COMPENSABILITY issues pursuant to §386-3. Attach WC-1 and/or WC-5.

___ TERMINATION OF TTD issues pursuant to §386-31(b). Attach termination letter and any disability certifications.

___ TERMINATION OF TPD issues pursuant to §386-32(b).

___ PERMANENT DISABILITY issues pursuant to §§386-31 and 386-32. Attach copy of rating report(s).

___ DISFIGUREMENT pursuant to §386-32.

___ DEPENDENT DEATH BENEFITS pursuant to §386-41. Attach WC-5A, Death Certificate, and all relevant marriage and birth certificates.

___ CONCURRENT EMPLOYMENT benefits pursuant to §386-51.5. Attach WC-14. Send copy of this request to the Special Compensation Fund.

___ REOPENING pursuant to §386-89. Attach relevant medical reports.

___ OTHER ISSUES. Identify all other issues (space provided below) to be dealt with at the hearing, and attach any other supporting documentation:

_____

_____

_____

_____

3. WITNESSES

Will there be any live witnesses? Yes ___ No ___ If yes, please complete the following section.

Witness(es) to be present at the hearing and/or those whose testimony will be submitted by way of a deposition transcript.

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

_____ _____

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

_____ _____

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

_____ _____

If necessary, please list additional names of witnesses and addresses on back page.

4. SPECIAL ACCOMMODATIONS

Are there any unusual or emergency conditions that you would like the Department to consider in calendaring this case for hearing? If yes, please explain:

_____

_____

_____

_____

_____

_____ _____

(Date) (Signature of Requestor)

5. NOTICE TO RECEIVING PARTIES:

YOU HAVE THE RIGHT TO FILE A RESPONSE TO THIS APPLICATION WITHIN 20 DAYS FROM THE RECEIPT OF THE APPLICATION FOR HEARING. YOU MUST FILE YOUR RESPONSE ON THE FORM "RESPONSE TO APPLICATION FOR HEARING."

Your request for a hearing has been denied for the following reason(s):

___ Lack of medical evidence.

___ Issue is not within the Department's jurisdiction.

___ Other:

_____

_____

_____

_____

_____ _____

(Date) (Hearings Review Section)